FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

FCP/142488

PRELIMINARY RECITALS

Pursuant to a petition filed July 23, 2012, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Waukesha County Health and Human Services in regard to Medical Assistance, a hearing was held on September 20, 2012, at Waukesha, Wisconsin.

The record was held open to give Waukesha County Health and Human Services (the agency) an opportunity to provide proof of social security and pension income. The documents have been marked collectively as Exhibit 17.

The issue for determination is whether the agency correctly determined Petitioner's spend down and cost share amounts.

NOTE: This case was initially assigned case number MGE/142112; which would denote a general medical assistance case. The case number was changed and corrected to FCP/142112 to reflect Petitioner's enrollment in the Family Care program.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Attorney L William Kahler
221 N Park St PO Box 89
Reedsburg, WI 53959-0089

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: Aina Bromberek
Waukesha County Health and Human Services
500 Riverview Avenue
Waukesha, WI 53188

ADMINISTRATIVE LAW JUDGE:
Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Waukesha County.
2. Petitioner is enrolled in Family Care Long Term Care, a subprogram of Medicaid.
3. On June 21, 2012, the agency sent Petitioner a Notice of Decision – Medicaid Income Allocation Notice, indicating that his Cost of Care Contribution was zero. According to this notice, the maximum community spouse income allocation was $2744.81. (Exhibit 10)
4. On June 22, 2012 and again on August 20, 2012, the agency sent Petitioner a notice indicating that effective July 1, 2012 and October 1, 2012, respectively, the required spend down amount for Family Care Benefits would be $2,357.03 per month. (Exhibits 6 and 15)
5. Petitioner, through his attorney, filed a request for fair hearing that was received by the Division of Hearings and Appeals on July 23, 2012, initially appealing a determination regarding Petitioner's countable assets. (Exhibit 2) However, on September 14, 2012, Petitioner's attorney submitted correspondence further disputing the spend-down determination (Exhibit 16).
6. Petitioner has no earned income.
7. Petitioner's total monthly unearned income from a pension and Social Security is $3020.30; $2236 Social Security Disability Income + $784.30 Pension income. (Exhibit 17)
8. Petitioner pays a monthly premium of $51.60 for health insurance. (Exhibit 5, pg. 12)
9. Petitioner's medical remedial expenses total $2509. (Exhibit 11)

DISCUSSION

The Family Care Program is a subprogram of Wisconsin's Medical Assi stance (MA) program and is intended to allow families to arrange for long-term community-based health care and support services for older or impaired family members without resort to institutionalization, *Wis. Stats.* §46.286; *Wis. Admin. Code* §DHS 10.11, *Medicaid Eligibility Handbook (MEH), §29.1.*

An individual, who meets the functional and financial requirements for Family Care, participates in Family Care by enrolling with a Care Management Organization (CMO), which, in turn, works with the participant and his/her family to develop an individualized plan of care. *See Wis. Stats.* §46.286(1) *and Wis. Admin. Code* §DHS 10.41. The CMO for Petitioner is Care Wisconsin.

Although Petitioner's initial appeal contested a determination concerning his countable assets, at the hearing the issue became moot because the agency indicated that at all times, Petitioner has been eligible for Family Care effective July 1, 2012, and that his assets did not exceed program limits. However, Petitioner, through correspondence from his attorney, raised a second issue, prior to the hearing, concerning the monthly spend down amount Petitioner must meet to maintain eligibility for Family Care. At the hearing, there was some discussion regarding and intermingling the terms "cost share" and "spend down".

There is no dispute that Petitioner has been found eligible for Family Care at the institutional level and that his income level subjects him to a cost share liability. However, the Petitioner asserts that the current, $2,357.03 spend down amount determined by the agency is not correct, because the agency failed

to take into consideration all of the insurance premiums paid by Petitioner and the Community Spouse Income Allocation (CSIA).

A person who receives both a Medical Assis tance card and Family Care, and is not on "regular MA" because of excess income, is classified as being in Group A, Group B, or Group C.

Group A is, in part, for people who are 18 and over who meet full benefit Elderly, Blind & Disabled (EBD) Medicaid financial and non-financial requirements and who are also functionally eligible for Family Care at either the nursing home or non-nursing home level of care. *MEH §29.3.1*. Petitioner does not meet the financial requirements for Medicaid, because his income is over the medically needy income limit of $591.67. Thus, Petitioner does not fit within Group A.

Group B status is available to people 18 and over who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for Family Care at the nursing home level of care, and whose income is at or below the Community Waivers Special Income Limit, which for a group of 1, is $2,094. *MEH, §§29.3.1 and 39.4.1* Petitioner's gross income of $3020.30 ($2236 Social Security Disability Income + $784.30 Pension Income) places him over the income limit for Group B status. Therefore, he is relegated to Group C status.

In order to be eligible for family care, a person in Group C status must expend income that exceeds the monthly medically needy income limit of $591.67. *MEH, §29.3.1.* This amount is known as a spend down amount:

> The spend down obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or Medicaid card services to lower countable income to the Medically Needy Income limit (See 39.4 EBD Assets and Income Tables) The care manager monitors and documents that this occurs monthly.
>
> A single Group C waivers participant must:
>
> 1. Incur, **and**
> 2. Be held financially responsible for the spend down amount on a monthly basis.
>
> A married Group C waivers participant must:
>
> 1. Incur the spend down amount, **and**
> 2. Pay the cost share monthly, if applicable.
>
> *MEH §28.5.2*

The spend down amount is calculated by subtracting the Medically needy income limit from an applicant's countable income. *See worksheet F-20919; MEH§28.8.1.* Countable income is determined using the following formula:

> Gross Earned Income
> -$65 and ½ earned income disregard
> + Total Unearned Income
> -$20 disregard
> -Special Exempt Income
> -Health Insurance Premiums
> -Excess Self Employment Expenses
> _____
> Countable Income *Id.*

As applied to Petitioner:

Petitioner had no earned income
$65 and ½ earned income disregard does not apply to Petitioner, because he had no earned income.

Petitioner's total unearned income:	$3020.30
$20.00 disregard:	-$20.00
Petitioner had no special exempt income	
Insurance premiums:	-$51.60
Petitioner had no excess self-employment expenses	
Countable Income:	$2948.70

Thus, petitioner's spend down amount is:

$2948.70 countable income – $591.67 Medically Needy Income Limit =$2357.03

The agency correctly determined the spend down amount.

It is unclear from the record why Petitioner is contesting the determination that the spend down amount is $2,357.03, given that the best information in the record is that the medical remedial expenses incurred by Petitioner are $2509 per month, which exceeds the spend down amount determined by the agency and renders Petitioner eligible for Family Care benefits. Thus, even if the agency incorrectly determined the spend down amount, Petitioner is still eligible for benefits.

Further, Petitioner submitted no documentation supporting any alleged health insurance expenses that would lower the agency's calculation of the spend down amount.

It should be noted that there appeared to be some confusion at the hearing regarding what the spend down amount was versus the cost share amount.

The spend down amount should not be confused with the cost share, which is the amount a Family Care participant must pay to the State, via the managed care organization, to partially offset the cost of his Medicaid services. *MEH §27.7.1; 28.8.3.6*

According to §27.7.1 of the *Medicaid Eligibility Handbook,* for a community waivers member, with or without a community spouse, the cost share is calculated following the directions in MEH §28.5.1, which states to follow directions in §28.7.3.1. That section states that a Personal Maintenance Allowance is used in determining the cost share calculation of a Group C waiver member, when completing section C of the Spousal Impoverishment Income Allocation Worksheet (worksheet 7) per §18.6.4, which provides directions to complete section C of worksheet 7 as follows:

1. Enter the institutionalized person's gross monthly income on Line 1. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.
2. Enter his/her personal allowance on Line 2:
    a. Personal Needs Allowance (39.4.2 EBD Deductions and Allowances) for a person in a medical institution, **or**
    b. Personal Maintenance Allowance for a person in community waivers. This is the Community Waivers Basic Needs Allowance (39.4.2 EBD Deductions and Allowances)

plus other applicable deductions (28.8.3.1 Personal Maintenance Allowance) up to the EBD Maximum Personal Maintenance Allowance amount (39.4.2 EBD Deductions and Allowances).

3. Enter on Line 4 the income allocation amount (Section A, Line 3) that is actually allocated to the community spouse.
4. Enter on Line 6 the dependent family member allowance from Section B, Line 4.
5. Enter on Line 8 any court-ordered guardian or attorney fees (27.6.6 Fees to Guardians or Attorneys).
6. Enter on Line 10 the institutionalized person's medical/remedial expenses and the cost of his/her health insurance premiums.
7. Do the math from Line 1 through Line 11. The result on Line 11 is the amount the institutionalized spouse must pay toward cost of care.

Following theses directions, Petitioner' s cost share appears to be zero, as stated in the notice sent to Petitioner on June 21, 2012:

Petitioner's Gross Income:	$3020.30
Community Waivers Basic Needs Allowance	- $878.00
Community Spouse Income Allocation (presumed)	-$2744.81
Remedial Medical/Health Insurance Costs	-$2509.00
	$ 0

If Petitioner's attorney wishes to contest the amount of the Community Spouse Income Allocation, he must do so in a separate appeal.

CONCLUSIONS OF LAW

The agency correctly deter mined Petitioner's spend down and cost share amounts.

THEREFORE, it is **ORDERED**

That the appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee, Wisconsin, this 9th day of October, 2012.

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Mayumi M. Ishii
Administrative Law Judge
Division of Hearings and Appeals

c: Waukesha County Health and Human Services - email
Department of Health Services - email
L William Kahler, Kahler Law Offices - e-mail

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

David H. Schwarz
Suite 201
5005 University Avenue
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on October 9, 2012.

Waukesha County Health and Human Services
Office of Family Care Expansion
kahler@mwt.net